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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/15/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: CT myelogram of lumbar spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Neurological Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of this reviewer that the request for a CT myelogram of the lumbar spine is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his low back when he was lifting and he twisted resulting in low back pain. The MRI of the lumbar spine dated 05/14/13 revealed facet degeneration at L5-S1. A small posterior central disc protrusion measuring 3mm was identified. A minimal broad based posterior disc bulge with a minimal left neuroforaminal narrowing was revealed. The clinical note dated 08/07/13 indicates the patient complaining of 6/10 pain in the low back. The patient reported numbness, tingling, and weakness in the left lower extremity. The patient had previously undergone physical therapy and has been treated with Etodolac, Hydrocodone, and Naprosyn for pain relief. Upon exam, the patient was able to demonstrate 60 degrees of lumbar flexion, 20 degrees of extension, and 10 degrees of bilateral lateral flexion. The patient demonstrated 4+/5 strength at the left EHL. The patient was recommended for an epidural steroid injection at that time. The clinical note dated 02/10/14 indicates the patient continuing with low back pain with radiation of pain into the left lower extremity. The radiating pain was identified at the lateral thigh and calf as well as the dorsal and lateral aspects of the left foot. The patient also had complaints of numbness and tingling in the same locations. The patient rated the pain as 7/10. 3/5 strength was identified at the gastrocnemius on the left with 4/5 strength at the tibialis anterior and the EHL on the left. Reflexes were 1+ at the left ankle. Hypoesthesia was identified over the L5 and S1 distributions on the left. The patient was recommended for a CT myelogram of the lumbar spine at that time.

The utilization review dated 03/04/14 resulted in a denial for a CT myelogram as no surgical intervention had been approved, thus not supporting the CT myelogram.

The utilization review dated 03/24/14 resulted in a denial for the CT myelogram as no significant changes were identified regarding the patient's progressive neurological

involvement.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient complaining of low back pain with associated strength deficits primarily in the left lower extremity. A CT myelogram would be indicated provided the patient meets specific criteria to include the need for surgical planning. There is an indication in the clinical notes that the patient was recommended for an epidural steroid injection following the completion of a course of physical therapy. However, it is unclear if the patient has completed the injection therapy as no information was submitted. No information was submitted on the most recent clinical notes confirming the patient having completed an epidural steroid injection. While the patient has demonstrated significant radiculopathy in the lower extremities associated with the L5-S1 distribution and therefore may benefit from additional imaging studies, given that the patient has not completed a full course of conservative treatments addressing the low back complaints, surgical planning would be premature at this time. Given this, the medical necessity for the CT myelogram of the lumbar spine has not been fully established. As such, it is the opinion of this reviewer that the request for a CT myelogram of the lumbar spine is not recommended as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)